

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

CERTIFICATE OF DEATH

02016

Reg. Dist. No. 5920

1. PLACE OF DEATH: Talbot

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street, address where death occurred:

Globe Road

How long in hospital or institution?

3. (a) FULL NAME

NETTIE K. BEAVEN

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widower

6. (b) Name of husband or wife: Rev. W. J. Beaven

7. Birth date of deceased (mo., day, yr.): December 9, 1863

8. AGE: Years 83 Months 2 Days 16 If less than one day: hrs. 0 min. 0

9. Birthplace: Talbot County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Gold Stone

12. Name: J. Thomas Kirby

13. Birthplace: Md.

14. Maiden name: Maggie Price

15. Birthplace: Md.

16. Informant: Mrs. Helen Beaven Grimes

Address: Easton, Md.

17. Burial: Date thereof: Feb. 25, 1947
(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: All Saints

Location: Longwood, Md. (Rural)

18. Funeral director: J. Delta Clark

Address: Easton, Md.

19. (Date rec'd by registrar) 2/24/47 (Date signed) 2-24-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton (If outside city or town limits, write RURAL and give nearest town)

Street No: Globe Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1947, at: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1947, to Feb 22, 1947, and that I last saw her alive on Feb 22, 1947.

Immediate cause of death:

Cerebral hemorrhage

DURATION

4 days

Due to:

Atherosclerosis

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: no

Date of op.:

Autopsy results:

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

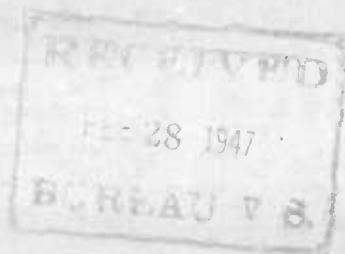
Means of injury:

Injured at work?

23. SIGNATURE: A. McC. Stevens M.D.

M. D. or other

Address: Easton Md. Date signed: 2-24-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16102

02017

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County: *Easton*City or town: *Easton, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial Hospital

How long in hospital or institution?

15 hrs.

3.(a) FULL NAME

Baby Boy Behlke

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

single

6.(b) Name of husband or wife

Mother *Mrs. Matilda Behlke*

Dentons, Md.

6.(c) If alive, give age

years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

15 hrs.

15

hrs.

min.

9. Birthplace

Easton, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name *Charles Behlke*

13. Birthplace Anchorage, Alaska

MOTHER

FATHER

14. Maiden name *Matilda Hennel*

15. Birthplace

Baltimore, Md.

16. Informant

Memorial Hospital

Address

Easton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Feb 22, 1947*

(month) (day) (year)

Cemetery or crematory

Easton

Location

Easton, Maryland

18. Funeral director

Virgil Moore & Son

Address

Easton, Maryland

19. (Date rec'd by registrar)

2/22/47

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Md.*County: *Caroline*City or town: *Denton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 22* 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 22 1947, to *Feb 22* 1947and that I last saw him alive on *February 22* 1947

Immediate cause of death

stillborn

DURATION

15 hours

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

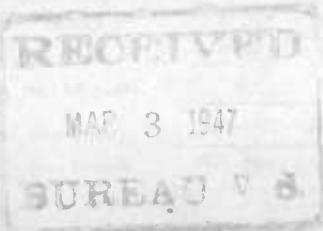
23. SIGNATURE

M. D. or other

Address: *West Cedar St. Anne MD*

Date signed

2/23



2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1200

02018

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

1. PLACE OF DEATH

County

Baltimore

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 da.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

5 day

3. (a) FULL NAME

Edith Brown

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Robert Brown

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

Oct. 17, 1903

8. AGE:

48

Years

3

Months

17

Days

It less than one day

hrs.

min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

H.W.

11. Industry or business

MOTHER

FATHER

12. Name

Charles Woelford

13. Birthplace

Md.

14. Maiden name

Bertha Kelson

15. Birthplace

Md.

16. Informant

Robert Brown

Address

Maryland Md.

17. Burial

Date thereof 2/6/47

(Burial, cremation, or removal which)

(month) (day) (year)

Cemetery or crematory

Greensboro

Location

Negro Greensboro, Md.

18. Funeral director

R.B. Pawling

Address

Greensboro, Md.

19. (Date recd by registrar)

19

47

N.H. Nevin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Caroline

City or town

Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb 3

1947, at 10²⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

1947

and that I last saw her alive on 2 to 3

19

Immediate cause of death

Cardiac Embolism

DURATION

Due to asthmatic heart

cyanosis

Due to asthma + abdominal distension

Other conditions, Hernia umbilical

strangulated.

(Include pregnancy within 8 months of death)

Major findings of operations, Tumor of transverse colon, Tumor of rectum, Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

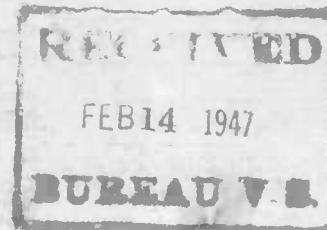
Mr. Palmer

M. D. or other

Address

Euston Md.

Date signed



2-35

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

02019

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
County Talbot
City or town Newcomb
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Ten year
Hospital, institution, or street address where death occurred:
Newcomb
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Newcomb
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Orpha Weston Burgess

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
Carl C. Burgess
6.(b) Name of husband or wife Carl C. Burgess
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 - 1883
8. AGE: Years 63 Months 3 Days 21 If less than one day hrs. min.

9. Birthplace Springport, Mich.
(town, county, and state)

10. Usual occupation House wife

11. Industry or business Charles Catt

MOTHER FATHER 12. Name Charles Catt
13. Birthplace Michigan

MOTHER 14. Maiden name Marion Gillette
15. Birthplace Michigan

16. Informant Carl C. Burgess
Address Newcomb, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof March 3 1947
(month) (day) (year)

Cemetery or crematory Spring Hill Cemetery
Location Easton, Md.

18. Funeral director John D. Williams
Address Easton, Md.

19. 3/3 1947 N. S. Nease
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1947, at 6:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 1946, to February 28 1947, and that I last saw her alive on February 28 1947.

Immediate cause of death arterial sclerosis
central

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -

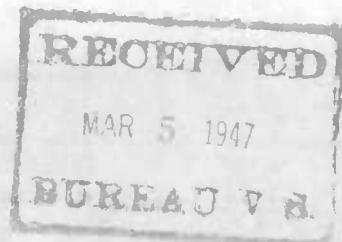
Where did injury occur? - (City or town) - (County) - (State) -

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Orla Burkman, M.D. M. D. or other -

Address Royal Oak, Md. Date signed 3/3



1-55-

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

CERTIFICATE OF DEATH

Reg. Dist. No. 021202700

1. PLACE OF DEATH:

County

Talbot

City or town

Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 minutes

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 30 minutes

3. (a) FULL NAME

Baby Boy Elben

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 1947

8. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

hrs. 30 min.

9. Birthplace

Easton, Talbot County, Md.

(Town, county, and state)

10. Usual occupation

Newborn

11. Industry or business

MOTHER FATHER

12. Name F. Cooper Elben

13. Birthplace Caroline County

14. Maiden name Evelyn Cross

15. Birthplace Queen Anne County

16. Informant F. Cooper Elben

Address

Denton, Md. RFD #3

17. Burial (Burial, cremation, or removal, which?)

Date thereof 2/20/47

(month) (day) (year)

Cemetery or crematory At Home on Farm

Location

Denton, Md.

18. Funeral director Mr. F. Cooper Elben

Address

Denton, Md.

19. 2/19/47

(Date rec'd by registrar)

D. A. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Denton, Md. RFD #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1947, at 3:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw him alive on 2-19-

1947

Immediate cause of death

Premature infant

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

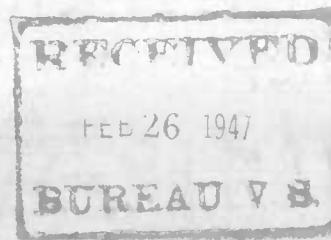
Means of injury

Injured at work?

23. SIGNATURE

George M. White M. D. or other

Address Date signed



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

02021
9910
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Talbot

County

St Michaels

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, Institution, or street address where death occurred:

Mulberry Street

How long in hospital or institution?

3. (a) FULL NAME

Marion H. Gillis, Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mary Baynard Gillis

6. (c) If alive, give age 65

years

7. Birth date of deceased (mo., day, yr.)

July 19, 1877.

8. AGE:

Years

Months

Days

If less than one day

69

7

7

hrs.

min.

9. Birthplace Salisbury, Md., Wicomico Co.

(Town, county, and state)

10. Usual occupation

Ice Manufacturer

11. Industry or business

Ice Plant

12. Name

George Gillis

13. Birthplace

Salisbury, Md.

14. Maiden name

Eliza Jane Gillis

15. Birthplace

Wicomico Co., Md.

16. Informant

Doctor Marion H. Gillis, Jr.,

Address

204 Walnut St., Salisbury, Md.

17. Burial

Date thereof March 1, 1947.

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Parsons

Cemetery or crematory

Salisbury, Md.

18. Funeral director

The Hill & Johnson Co.,

Address

Salisbury, Maryland.

19. Mar 1, 1947
(Date rec'd by registrar)

d. Atresia

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Talbot

City or town St Michaels

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1947. 19..... at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Feb. 1947, to 26 Feb. 1947, and that I last saw him alive on 26 Feb. 1947.

Immediate cause of death Congestive Heart Failure

Due to Cardiac disease

95-2 10 years DURATION

Due to

Other conditions asthma, chronic, bronchial

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

W. Herbert Morrison, M. D.
St Michaels, Md. Date signed 1 Mar. 47

RECEIVED

MAR 17 1947

BUREAU OF INVESTIGATION

RECEIVED

MAR 17 1947

BUREAU OF INVESTIGATION

2435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE, DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02022

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Salisbury
 City or town Oxford, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs

Hospital, institution, or street address where death occurred:

Easton Memorial Hosp.How long in hospital or institution? 4 hrs

3(a) FULL NAME

Henry Thomas
Mrs. Donald J. Haddaway

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

<u>M</u>	<u>W</u>	<u>Married</u>
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6. (b) Name of husband or wife

Mrs. Van J. Haddaway

7. Birth date of deceased (mo., day, yr.)

Aug. 14, 19116. (c) If alive, give age 26 years

8. AGE:

Years <u>25</u>	Months <u>6</u>	Days <u>9</u>	If less than one day
-----------------	-----------------	---------------	----------------------

hrs. min.

9. Birthplace

Oxford, Md.
 (Town, county, and state)

10. Usual occupation

Tobemaster

11. Industry or business

Poultry plant

FATHER

12. Name Julius Haddaway

13. Birthplace

Oxford, Md.

MOTHER

14. Maiden name Lillian Hill

15. Birthplace

Oxford, Md.

16. Informant

Mrs. D. J. Haddaway

Address

Oxford, Md.

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof 2/25/47
 (month) (day) (year)

Cemetery or crematory

Oxford

Location

Oxford, Md.

18. Funeral director

Maryland & Maryland

Address

Easton, Md.19. 2/2419. 47 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SalisburyCity or town Oxford
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-14-2060

MEDICAL CERTIFICATION

20. DATE OF DEATH

22 Feb19. 47 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 Feb19. 47 to22 Feb 19. 47and that I last saw h. alive on 22 Feb 19. 47Immediate cause of death Cardiac failure

DURATION

2Due to Coronary Thrombosis

?

Due to

Other conditions Obesity due to over food

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

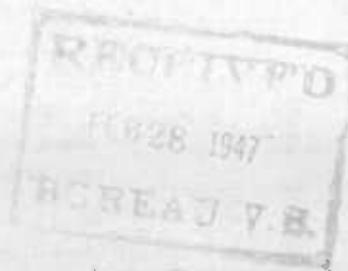
Injured at work?

23. SIGNATURE

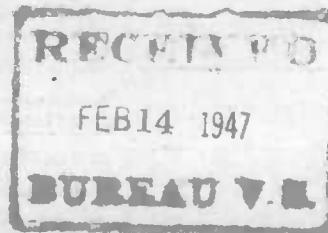
Henry Thomas H. D.

M. D. or other

Address 204 E. Elm St. Easton Date signed 22 Feb 47



1 - 35



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

02024

CERTIFICATE OF DEATH

Reg. Dist. No.

2900

1. PLACE OF DEATH:

County *Baltimore*City or town *Easton*(If outside city or town limits, write RURAL and give nearest town) *md Rural*How long in above place of death? *50 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JOHN RICHARD HOPKINS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

February 8, 1881

8. AGE:

Years

Months

Days

If less than one day

*66**3**hrs.**min.*

9. Birthplace

Acting Talbot Co. Md. R. P.

(Town, county, and state)

10. Usual occupation

Gardener

11. Industry or business

Clarence B. Hopkins

12. Name

Clarence B. Hopkins

13. Birthplace

Large Mill, Md. Talbot Co.

14. Maiden name

Anna Williams

15. Birthplace

Kent County, Maryland

16. Informant

Mrs. Emily Hopkins

Address

Easton Md.

17. Burial

*Burial*Date thereof *Feb. 15, 1947*

(month) (day) (year)

Cemetery or crematory

Large Mill Cemetery

Location

Large Mill, Md.

18. Funeral director

Acting Talbot Co.

Address

Easton Md.

19. 2/11/47

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md*County *Talbot*City or town *Easton*(If outside city or town limits, write RURAL and give nearest town) *R.D.*

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

February 11, 1947 at *11:00 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 1947 to *Feb. 4 1947*and that I last saw him alive on *January 28 1947*

Immediate cause of death

T.B. of the lungs

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

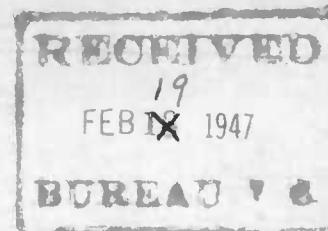
23. SIGNATURE

Kurt Lederer M.D.

M. D. or other

Address

*Acton Ave 440*Date signed *2/13/47*



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2159

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County *Baltimore*City or town *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 days*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Mary Jenkins*4. Sex *F*5. Color of race *W*6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) *January 2 1867*6. (c) If alive, give age *years*8. AGE: Years *85*Months *1*Days *22*

If less than one day

hrs. *00*

min.

9. Birthplace *Baltimore, Maryland*

(Town, county, and state)

10. Usual occupation *Housekeeper*

11. Industry or business

12. Name *Edward Jenkins*13. Birthplace *Baltimore*14. Maiden name *Elizabeth Dawson*15. Birthplace *Baltimore*16. Informant *Mrs. Gale Morgan*Address *1000 Piedmont Washington DC*

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof *Feb 24 1947*

(month) (day) (year)

Cemetery or crematory *Spring Hill*Location *Baltimore Maryland*18. Funeral director *Miller Clark*Address *Baltimore Maryland*19. *2/24 1947* (Date rec'd by registrar)*M. A. Neurus*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Baltimore*City or town *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Washington*

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 24*1947, at *3:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased for

August 1st, 1946, to Feb 24 1947 and that I last saw her *alive* on *Feb 24 1947*Immediate cause of death *Impression of the head or the Pancreas* DURATIONDue to *Impression of the head or the Pancreas* *6 mo.*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

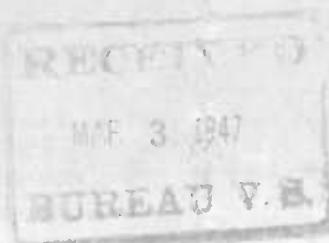
23. SIGNATURE *William S. Seymour*

M. D. or other

Address:

Date signed:

2159



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

02025

CERTIFICATE OF DEATH

Reg. Dist. No.

2941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Talbot
City or town Clairborne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Theodore J. Jones Jr.4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Juliana Jones7. Birth date of deceased (mo., day, yr.) Mar. 13 18726. (c) If alive, give age 72 years8. AGE: Years 74 Months 11 Days 12 If less than one day hrs. min.9. Birthplace Bogman
(Town, county, and state)10. Usual occupation Merchant11. Industry or business General Merchant12. Name Theodore J. Jones Jr.13. Birthplace Bogman, Talbot Co. Md.14. Maiden name Nancy Harrison15. Birthplace Bogman, Talbot Co. Md.16. Informant Ole JonesAddress Clairborne, Md.17. Burial Burial Date thereof Feb. 27. 1947
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Family Burying GroundLocation Bogman Md of18. Funeral director Newman & HarrisonAddress St Michaels. Md19. Feb. 26 1947 Anna C. Thomas
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Clairborne (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 February 1947 at 8:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 February 1947 to 25 Feb. 1947 and that I last saw him ~~alive~~ on 23 February 1947.Immediate cause of death Dehydration and malnutrition DURATION 18.47Due to Parkinsonism 8 years

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE W. Herbert Morrison M. D. or otherAddress St Michaels Date signed 26 Feb. 47

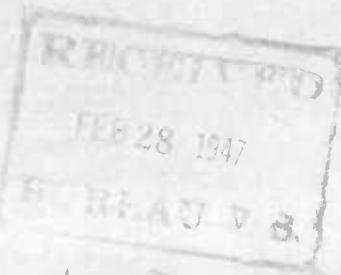
RECEIVED

MAR 6 1947

BUREAU

2-25-

2-2940 - 2-10



1 - 35 -

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

02027

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County

Talbot

City or town

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Harrison Leonard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Mary E. Dawson

7. Birth date of deceased (mo., day, yr.)

Dec 2, 1863

6. (c) If alive, give age 71 years

8. AGE:

Years 83 Months 2 Days 22 If less than one day

9. Birthplace

Trappe, Md.

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

12. Name Thomas A. Leonard

13. Birthplace Trappe, Md.

14. Maiden name Olivia L. Parrott

15. Birthplace Baltimore, Md.

16. Informant Mrs. Florence Tarbutton

Address Easton, Md.

17. Burial

Date thereof Feb 27 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18. Funeral director John D. Williams

Address Easton, Maryland

19. 2/26 1947 11 A.M. New

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Harrison

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1947 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6th 1947 to Feb. 24th 1947

and held last saw him alive on Feb. 24th 1947

Immediate cause of death

Carcinoma of the Sigmoid

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

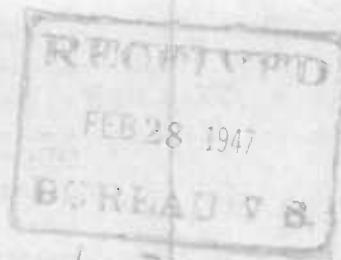
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Easton, Md. Date signed 2-25-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02028

CERTIFICATE OF DEATH

Reg. Distr. No. 290

1. PLACE OF DEATH:

County *Baltimore*City or town *Baltimore, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *10 yrs.*Hospital, institution, or street address where death occurred: *Baltimore*

How long in hospital or institution?

3. (a) FULL NAME

Walter Willis Long

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W.

Married

6. (b) Name of husband or wife *Mary B. Long*6. (c) If alive, give age *51* years7. Birth date of deceased (mo., day, yr.) *Dec 20 1874*8. AGE: Years *77* Months *6* Days *0* If less than one day *hrs. 0* min. *0*9. Birthplace *Rockingham County, Va.*

(Town, county, and state)

10. Usual occupation *Farmer*11. Industry or business *Thomas Long*12. Name *Thomas Long*13. Birthplace *Va.*14. Maiden name *Lucie Sanders*15. Birthplace *Va.*16. Informant *Mrs. W. W. Long*Address *Baltimore, Md.*17. Burial Date thereof *March 6, 1947*(Burial, cremation, or removal. Which?) *Burial* (month) (date) (year)Cemetery or crematory *Spring Hill*Location *Baltimore, Md.*18. Funeral director *Allen Park*Address *Baltimore, Md.*19. Date rec'd by registrar *2/28/47*(Date rec'd by registrar) *1947*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Baltimore*City or town *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 26, 1947* at *10:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 1946 to *26 Feb. 1947* *1947* to *1947*and that I last saw h. *alive* on *June* *1946*

Immediate cause of death

*Automobile accident*Due to *Hypertension cardiovascular disease*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *1947*Where did injury occur? *(City or town) (County) (State)*

Injured at home, farm, industry, public place (where?)

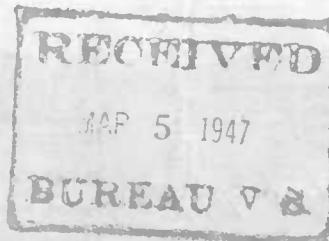
Means of injury

Injured at work?

23. SIGNATURE *Reuben Harrison*

M. D. or other

Address *207 E. Love St. Carlton*Date signed *27 Feb 1947*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02029

CERTIFICATE OF DEATH

159 Reg. Dia. No. 2900

1. PLACE OF DEATH

County

Talbot

City or town

Easton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 15 min.

3. (a) FULL NAME

Marvel, Baby Boy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 24, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

..... hrs. 15 min.

9. Birthplace Memorial Hospital

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Warner Marvel

13. Birthplace Talbot County

14. Maiden name Louise Harrington

15. Birthplace Talbot Co.

16. Informant Memorial Hospital

Address

Easton Md.

17. Cremation

Date thereof 3/4/47

(Burial, cremation, or removal. Which?)

Cemetery or crematory Memorial Hosp.

Location

Easton Md.

18. Funeral director

Memorial Hospital

Address

Easton Md.

19. Date rec'd by registrar

19-47

M. D. or other

(Date rec'd by registrar)

Date signed

Registrar

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Talbot

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-24

19

47, et 4 05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h.....alive on

19.....

Immediate cause of death

Premature

DURATION

Due to

Premature

3 mos

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Retained placenta

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. S. Noble

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 11 1947

H. K. READ & CO.

2-35

PLEASE WRITE PLAINLY, WITH ~~UN~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MC*

CERTIFICATE OF DEATH

Reg. Dist. No.

02030 2910

1. PLACE OF DEATH:

County *Garbat*City or town *Newcombe*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 months*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Arthur McCarthy

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

- w -

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 30, 1882

If alive, give age years

8. AGE:

Years *64*Months *8*Days *13*If less than one day
hrs. *.....* min. *.....*

9. Birthplace

(Town, county, and state)

*Florida**retired*

10. Usual occupation

11. Industry or business

12. Name *John McCarthy*13. Birthplace *Ireland*14. Maiden name *unknown*

15. Birthplace

16. Informant

17. Burial *John McCarthy*Address *Langhorne Pa.*Date thereof *Feb 17, 1947*

(month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory *Beechwood Cemetery*Location *Hulmeville Pa*18. Funeral director *McNamara & Harrison*Address *St. Michaels Ind.*19. Date rec'd by registrar *Feb 18, 1947 John Haworth*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *N.Y.* County *Bronx*City or town *Astoria Long Island*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *1473-30th Street*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 13 1947

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death

Acute alcoholism

DURATION

Due to.....

Due to.....

Other conditions *Partial gastrectomy*
2 yrs ago -

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

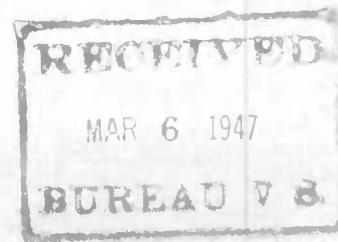
Injured at work?

23. SIGNATURE

Louis J. Wally M.D. D.P.M.

M.D. or other

Address *Boston Md* Date signed *2-13-47*



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

CERTIFICATE OF DEATH

02031

MV

Reg. Dist. No.

2900

1. PLACE OF DEATH: Talbot
 County Boston
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, Institution, or street address where death occurred: Emergency Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Hurlock (Rural)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war? No

3. (a) FULL NAME
Guy Franklin Molock

3. (b) Social Security Number
218-07-5999

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife M. Marie Molock

7. Birth date of deceased (mo., day, yr.) May 30, 1910 8. (c) If alive, give age 32 years

8. AGE: Years 36 Months 8 Days 9 If less than one day hrs. min.

9. Birthplace Dorchester County, Maryland
 (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Continental Can Company

12. Name Abraham L. Molock

13. Birthplace Dorchester County, Maryland

14. Maiden name Susie Lartin

15. Birthplace Kent County, Maryland

16. Informant Mrs. M. Marie Molock

Address Hurlock, Maryland

17. Burial Washington Cemetery Date thereof Feb. 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Cemetery

Location Near Hurlock, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. 2/12/47 Date rec'd by registrar N. J. Neary
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

X to X on 19 and that I last saw him X alive on X on 19

Immediate cause of death

Fracture at Base of Skull

DURATION

1 day

Due to

Due to

Other conditions Fractures of both legs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb. 9/47

Where did injury occur? Hurlock Dorchester, Md. (City or town) (County) (State)

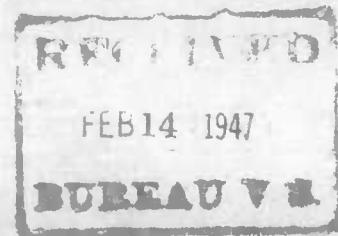
Injured at home, farm, industry, public place (where?) N. Main St.

Means of injury Automobile Injured at work? no

23. SIGNATURE

J. R. Shriver - Dep. Med. Exam. M. D. or other

Address Cambridge, Md. Date signed Feb. 9/47



1-35-

PLEASE WRITE PLAINLY, WITH UPPERCASE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-2

CERTIFICATE OF DEATH

Reg. Dist. No. 290

02/132

1. PLACE OF DEATH:
County Talbot County

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street, address, where death occurred:
Memorial Hospital

How long in hospital or institution? 12 hours

3. (a) FULL NAME Ann Alice Nixon

4. Sex F 5. Color or race B W 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Albert Nixon

7. Birth date of deceased (mo., day, yr.) May 10, 1860 6. (c) If alive, give age years

8. AGE: Years 86 Months 80 Days 14 If less than one day hrs. min.

9. Birthplace Nevre de Grace Md
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business Solomon Banks

MOTHER FATHER 12. Name Salomon Banks

13. Birthplace Nevre de Grace Md

14. Maiden name Unknown

15. Birthplace "

16. Informant Leon W. Henry

Address Easton Md

17. Burial, cremation, or removal. Which? Cemetery Date thereof Mar. 12 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Treppes Md

18. Funeral director Leon W. Henry

Address Easton Md

19. (Date rec'd by registrar) 2/28 19. 47 NY 11111111 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Treppes
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1947 at 2:55 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26-47 to 2-27-47 and that I last saw him alive on 2-26-47.Immediate cause of death Shock DURATION 6 hoursDue to Vascular Collapse 8 hrs.Due to Strangulated Femoral Hernia left

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Strangulated femoral Hernia left - released Date of op. 2-26-47Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

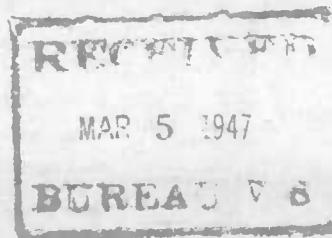
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. B. Ambler MD M. D. or other MD Date signed 2-27-47Address Easton Md



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

02033

1. PLACE OF DEATH:

County BaltimoreCity or town BaltimoreHow long in above place of death? 2 daysHospital, Institution, or street address where death occurred: 2401 Marion HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

Mrs. Mary Osborne4. Sex F5. Color or race W6. (u) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Arthur Osborne7. Birth date of deceased (mo., day, yr.) 18986. (c) If alive, give age 51 years8. AGE: Years 49

Months

Days

If less than one day

hrs. 0 min. 09. Birthplace Md.

(Town, county, and state)

H. W.

10. Usual occupation.

11. Industry or business

FATHER

12. Name Joseph Andrews13. Birthplace Hurlock, Md.

MOTHER

14. Maiden name Mary Todd15. Birthplace Md.16. Informant Arthur OsborneAddress Hurlock

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 28 1947 (month) (day) (year)Cemetery or crematory Baltimore CemeteryLocation Hurlock18. Funeral director F.B. WiloughbyAddress Hurlock19. (Date rec'd by registrar) 2/26/47

19. (Date of)

19. (Year)

N. H. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Hurlock

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2519. 47 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 10 1947 to Feb 25 1947and that I last saw her alive on Feb 25 1947

Immediate cause of death

Coronary Thrombosis.

DURATION

immediateDue to Bronch Pneumonia left1 dayDue to Diabetic coma -10 hr.Other conditions Cold bacillus infection8 yrs.left kidney.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. E. Germann M.D.

M. D. or other

Address HurlockDate signed 2/27/47

RECEIVED

MAR 3 1947

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

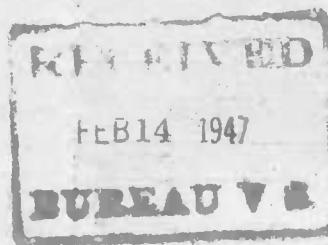
02034

Reg. Dist. No

2900

1. PLACE OF DEATH County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... Hospital, Institution, or street address where death occurred:			Street No..... (If rural, give LOCATION)			
How long in hospital or institution?.....			2.(a) If veteran, name war.....			
3. (a) FULL NAME <i>Samuel Silverman</i>			3. (b) Social Security Number			
4. Sex <i>M.</i>	5. Color or race <i>70.</i>	6.(a) Single, married, widowed, or divorced <i>Widower</i>	MEDICAL CERTIFICATION			
6.(b) Name of husband or wife..... <i>Anna Silverman</i>			20. DATE OF DEATH..... <i>Feb. 8</i>	19. <i>47</i> , at <i>8:30 P</i>		
7. Birth date of deceased (mo., day, yr.) <i>July 4, 1870</i>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>November 16</i> to <i>February 8</i> 19. <i>47</i> and that I last saw him alive on <i>Feb. 8</i> 19. <i>47</i>			
8. AGE: Years <i>76</i> Months <i>9</i> Days <i>5</i> If less than one day hrs. min.			Immediate cause of death <i>Carcinoma of larynx</i>			
9. Birthplace..... (Town, county, and state) <i>Poland</i>			DURATION <i>41</i>			
10. Usual occupation..... <i>None</i>			Due to.....			
11. Industry or business			Due to.....			
MOTHER FATHER	12. Name..... <i>Marie Silverman</i>			Other conditions.....		
	13. Birthplace <i>Poland</i>			(Include pregnancy within 8 months of death)		
	14. Maiden name..... <i>Magie Albert</i>			Major findings of operations.....		
	15. Birthplace <i>Poland</i>			Date of op.		
	16. Informant..... <i>C. C. Silverman</i>			Autopsy results.....		
Address..... <i>Canton - Md.</i>			PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial, cremation, or removal, (which?) <i>Funeral</i> Date thereof..... (month) <i>Feb</i> (day) <i>13</i> (year) <i>1947</i>			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....			
Cemetery or crematory..... <i>Asburyville, N.C.</i>			Where did injury occur?..... (City or town)..... (County)..... (State).....			
Location..... <i>Nashville, N.C.</i>			Injured at home, farm, industry, public place (where?).....			
18. Funeral director..... <i>Philis Banks</i>			Means of injury..... Injured at work?.....			
Address..... <i>Canton - Md.</i>			23. SIGNATURE..... <i>Martin F. Buel, M.D.</i> M. D. or other..... Address..... <i>Canton, Maryland</i> Date signed <i>2-10-47</i>			
19. <i>2/9</i> 19. <i>47</i> N.H. Neeries (Date fed day registrar)						
Registrar						

23. SIGNATURE John T. S. Smith, Jr. M. D. or other 2-10-47.
Address Easton, Maryland Date signed 2-10-47.



2-35-

Evidence for the change of
age is shown on

G 108 2/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02035

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County TalbotCity or town Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial HospitalHow long in hospital or institution? 4 days

3. (a) FULL NAME

Mr George B Stewart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

B. (b) Name of husband or wife

Mrs Evelyn Stewart

7. Birth date of

deceased (mo., day, yr.)

Aug 1 1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71 75 5 1 hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Druggit

11. Industry or business

own business

MOTHER FATHER

12. Name

James B Stewart

13. Birthplace

Maryland

14. Maiden name

Marietta Layton

15. Birthplace

Maryland

16. Informant

Mrs Stewart

Address

Hillsboro, Maryland

17. Burial

Date thereof 2/15/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillsboro

Location

Hillsboro Md.

18. Funeral director

R. B. Rawlings

Address

Greensboro, Md.19. 2/319 47M.A. Deere

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Hillsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 15, 1947 at 10 1/2 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 Jan 1947 to 2 Feb 1947 1947and that I last saw him alive on 2 Feb 1947 1947Immediate cause of death Cardiac failure dueto myocardial infarction dueto hypertension with arterio-scleroticDue to heart disease

Due to

Other conditions Diabetes mellitus

DURATION

4 weeks

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

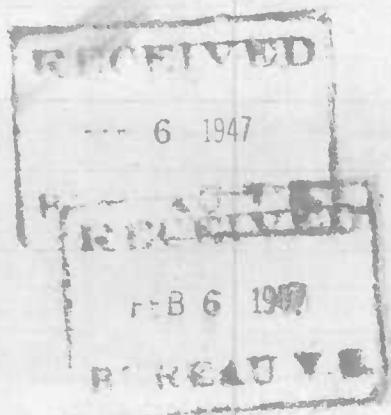
Injured at work?

23. SIGNATURE

Robert Harris M.D.

M.D. or other

Address 214 E. Lower St. Easton, MarylandDate signed Feb 17, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02036

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution or street address where death occurred:

Eastern Memorial Hosp.How long in hospital or institution? 15 days

3. (a) FULL NAME

Randolph Thomas

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M B. T marriedB. (b) Name of husband or wife Flinnie Thomas7. Birth date of deceased (mo., day, yr.) Unknown 18646. (c) If alive, give age 45 years8. AGE: Years 83 Months Days If less than one day hrs. min. 9. Birthplace Norfolk Va.

(Town, county, and state)

10. Usual occupation most Laborer11. Industry or business Cannery12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant Annie ThomasAddress Hillsboro Md.17. Burial Date thereof 2/12/47(Burial, cremation, or removal. Which?) Burial (month) (day) (year)Cemetery or crematory GreenmountLocation Hillsboro, Md.18. Funeral director John F. SchneiderAddress Edison Yld.19. (Date rec'd by registrar) 2/11/47 19 47 N. H. Neirns

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Baltimore Co.City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 19 47 at 405 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Feb 7 19 47 Feb 9 19 47and that I last saw him alive on Feb 9 19 47Immediate cause of death ArrestedDURATION ArrestedDue to Hypertrophied
prostateDue to Sclerotic kidneys
ArteriosclerosisOther conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

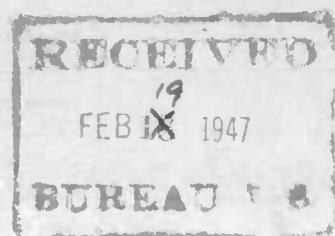
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? 23. SIGNATURE John F. Schneider, M.D. M. D. or other Address Baltimore, Md. Date signed Feb 10, 1947



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